SPECIALIZED TREATMENT FACILITY
PHARMACEUTICAL BID

Program: Specialized Treatment Facility

Average Number of Non-Medicaid/Medicare Prescriptions Filled Per Month (for dispensing fee purposes): 400

Company Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Name of Person Completing Bid: _____

1. Percentage Above/Below Average Wholesale Price (AWP): % Above AWP _____ % Below AWP _____
2. Dispensing Fee Per Prescription: _____
3. Will provide 24 hour/365 day per year on-call availability to fill prescription medications. ☐Yes ☐No
4. Will provide medication delivery seven (7) days per week. ☐Yes ☐No
5. Will deliver stat medications within one hour of order. ☐Yes ☐No
6. Will carry extensive stock of injectables (Haldol, Geodon, Rocephin, Ativan). ☐Yes ☐No
7. Will blister-pack required medications. ☐Yes ☐No
8. Will provide medictions/treatments within 24 hours of order with exception of products that must be ordered from a supplier if not in stock or available at the time of order. ☐Yes ☐No
9. Will provide fourteen (14) day supply of all medications within 24 hours of a "named storm". ☐Yes ☐No
10. Will support Emergency Medication Kits regulations and replace out of date medications with proper quantities. ☐Yes ☐No
11. Will invoice (via receipt) STF for costs of medications/related supplies not covered by client's Medicaid, Medicare and/or private insurance. ☐Yes ☐No

Signature of Person Submitting Bid:_____ Date: _____